# EPSDT Appendix A

**Last Updated: 04/04/2022**

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# EPSDT Appendix A

## INTRODUCTION

Service authorization, formerly known as prior authorization, is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some may begin prior to requesting authorization.

## PURPOSE OF SERVICE AUTHORIZATION

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued enrollment as a DMAS provider, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

## GENERAL INFORMATION REGARDING SERVICE AUTHORIZATION

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

The service authorization entity will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical necessity criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review within 30 days from the date they are aware of the member's Medicaid eligibility determination.

**MEDICAID MANAGED CARE**

Children enrolled in Commonwealth Coordinated Care Plus (CCC Plus)

CCC Plus is a statewide Medicaid managed care program that serves individuals with complex care needs, including children enrolled in Home and Community Based Waivers, through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports. Children enrolled in CCC Plus, with the exception of those children enrolled in the CL and FIS Waivers, may receive EPSDT Personal Care Services through the MCO. Providers and families should contact the MCO for information on obtaining service authorization for EPSDT Personal Care. Contact information for CCC Plus MCOs is located at https://cccplusva.com/home

Children enrolled in Medallion 4.0

MEDALLION 4.0 provides the delivery of acute and primary care services, prescription drug coverage, and behavioral health services (as specified) for eligible Medicaid, Medicaid Expansion, and FAMIS members Detailed information on the Medallion 4.0 Program can be found on the Medallion 4.0 Program webpage at http://www.dmas.virginia.gov/#/med4. Contact information for Medallion 4.0 MCOs is located at https://www.virginiamanagedcare.com/

**MEMBERS TRANSITIONING INTO MANAGED CARE**

For members that transition into managed care, the health plans will honor the Service authorizationservice authorization contractor's authorization for a period of not less than 30 days or until the Service authorization ends whichever is sooner, for providers that are in- and out of network.

When a member enrolls in one of the managed care plans, the provider should contact thehealth plan to obtain an authorization and information regarding billing for services.

**MEMBERS TRANSITIONING FROM MANAGED CARE TO MEDICAID FEE-FOR SERVICE (FFS)**

Should a member transition from managed care to Medicaid FFS, the provider must submit a request to the Service authorization contractor and needs to advise the Service authorizationservices authorization Contractor that the request is for a managed care transfer within 30 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Service authorization Contractor will honor the managed care approval up to the last approved date but no more than 30 calendar days from the date of managed care disenrollment under the continuity of care provisions. For continuation of services beyond the 30 days, the Service authorization contractor will apply medical necessity/service criteria.

Should the request be submitted to the Service authorization Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 30-day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from managed care at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Service authorization Contractor's service authorization but the member's managed care eligibility has been retro-voided, continuity of care days will not be approved by the managed care health plan and will not be on the transition reports since the member never went into managed care. The Service authorization contractor will re-open the original service authorization for the same provider upon provider notification.

**Managed Care Exceptions:**

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Service authorization Contractor will honor the managed care approved days/units under the continuity of care period for up to 30 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under managed care for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from managed care to FFS, and the provider requests an authorization for a service not previously authorized under managed care, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Service authorization Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

Additional information on the CCC Plus program is available on the DMAS website at http://www.dmas.virginia.gov/#/cccplus. Medallion 4.0 information is located athttp://www.dmas.virginia.gov/#/med4.

**CHANGES IN BENEFIT PLANS**

Because the individual may transition between fee-for-service and the DMAS contracted managed care program, the service authorization entity will honor the DMAS contracted Managed Care Organization (MCO) service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor a service authorization based upon proof of authorization from the provider, DMAS, or the service authorization contractor for services authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO. The MCO must initially honor the service authorizations issued by DMAS or its contractors from the date an individual enrolls in the MCO but may reevaluate the service authorization for medical necessity as specified by the managed care contract.

Service authorization decisions by DMAS or its contractor are based upon clinical review and apply only to individuals enrolled in Medicaid or FAMIS fee-for-service or services carved on dates of service requested. The service authorization decision does not guarantee Medicaid or FAMIS eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for MCO enrollment. For MCO enrolled members, the provider must follow the MCO's service authorization policy and billing guidelines.

**COMMUNICATION**

Provider manuals are located on the DMAS portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Additional service authorization information is located on the current service authorization contractor's website, http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The service authorization entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in

this manual will be posted in the form of a Medicaid Memo to the DMAS web portal. Changes will be incorporated within the manual.

**EPSDT SERVICES REVIEWED BY DBHDS**

The following EPSDT services are reviewed by the Department of Behavioral Health and Developmental Services (DBHDS) for children enrolled in the Community Living (CL) Waiver, Family and Individual Support (FIS) Waiver and Building Independence Waiver (BI):

- EPSDT Assistive Technology
- EPSDT Private Duty Nursing
- EPSDT Personal Care

DBHDS reviews these services only for children already enrolled in the CL, FIS and BI Waivers. The CL, FIS and BI Waivers were previously known as the Intellectual Disabilities (ID) Waiver, Individual and Family Developmental Disabilities Support Waiver (DD) Waiver and the Day Support Waiver. The three waivers are referred to collectively as the DD Waivers. All requests for EPSDT Private Duty Nursing, EPSDT Personal Care and EPSDT Assistive Technology for children enrolled in the CL and FIS Waivers must be submitted to DBHDS via the Waiver Management System (WaMS) by the individual's support coordinator. All required service authorization forms and documentation for these services as outlined in the EPSDT Supplement must be submitted to DBHDS for service authorization. For additional information, contact DBHDS at 804-663-7290.

**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT AND CCC PLUS WAIVER FOR INDIVIDUALS UNDER THE AGE OF 21**

Effective September 1, 2018, individuals under the age of 21, enrolled in the CCC Plus

Waiver, must receive personal care, private duty nursing, and assistive technology through the Early Periodic Screening and Diagnostic Treatment (EPSDT) benefit. Service authorization requests for these services are to be submitted to either the respective Managed Care Organization (MCO) for individuals enrolled in managed care or to KEPRO through the Atrezzo Connect provider portal for Fee-for-Service. The Managed care plans and KEPRO will utilize EPSDT rules and required documentation in authorizing these services.

## SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

For EPSDT services, KEPRO accepts service authorization requests through direct data entry (DDE), fax, phone and US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the end of the current authorization in order for submissions to be timely and to avoid any gaps in service.

## PROCEDURAL CHANGE FOR THE REVIEW OF FEE-FOR-SERVICE EPSDT PERSONAL CARE SERVICE AUTHORIZATION REQUESTS

Effective September 1, 2018, service authorization requests for EPSDT Personal/Attendant Care will be accepted and reviewed by KEPRO. Providers will continue to use KEPRO's secure portal, Atrezzo for submittals. The requests will continue to be processed by KEPRO with the preexisting standard of five (5) business days.

Providers will continue to submit the DMAS-7, DMAS 7-A and the personal care questionnaire or DMAS- 99.

### How to Register for Atrezzo

Provider registration is required to use Atrezzo Connect. The registration process for

providers happens immediately on-line. To register, go to http://dmas.kepro.com, and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KEPRO.

Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to http://dmas.kepro.com.

**Already Registered with Atrezzo but Need Help Submitting Requests**

It is imperative that providers currently registered use the portal for submitting all requests. For EPSDT Personal Care and Private Duty Nursing providers, this includes admissions, discharges, continuation of care, change in hours, transfers, responding to pend requests, and all other transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but needs assistance submitting requests through the portal, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to have a new administrator set up.

When contacting KEPRO please leave caller's full name, area code and phone number and the best time to be contacted.

**Additional Information for Ease of Electronic Submission**

In order to make this transition to electronic submission easier for the providers, KEPRO and DMAS have completed the following:

1. Attestations – All providers will attest electronically that information submitted to KEPRO is within the member's documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

2. Questionnaires for EPSDT Private Duty Nursing and EPSDT Personal Care services were reconfigured by KEPRO and DMAS. The questionnaires are shorter, require less information, take less time to complete, and are more user friendly.

*Faxing Requests to KEPRO*

Providers must use the specific fax form required by KEPRO when requesting the services listed below. If the fax form is not accompanied by the request, KEPRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. KEPRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms for the services below, service authorization checklists, questionnaires for certain services, trainings, and much more are on KEPRO's website. Providers may access this information by going to http://dmas.kepro.com.

Required Forms:

- EPSDT Assistive Technology – DMAS 363
- Hearing Aids and related devices – DMAS 363

*Checklists and Questionnaires*

Service authorization checklists and questionnaires (specific to certain services) may be accessed on KEPRO's website to assist the provider in assuring specific information is included in the electronic request in order to make a final determination for a service. Information from the DMAS required form(s) and/or required documentation may be used to complete a checklist or questionnaire. The service authorization checklists are not mandatory in order to complete the request.

If providers who submit requests for EPSDT Assistive Technology, Hearing Aids and related devices do not wish to use the service authorization checklist for web based requests, the provider may submit the completed required DMAS form(s) and/or required documentation as an attachment to the request when it is submitted.

****Note to providers, the information submitted to KEPRO for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information to KEPRO containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**Timeliness of Submission by Providers**

*For Services with Timely Submittal Requirement:*

Providers must submit requests to KEPRO within the required time frames for each service request. See Exhibit 2 in this Appendix for specific service submittal time frames for each service type. If a provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KEPRO will review completed requests within the appropriate timeframe for the specific service requested and make a final determination.

Note: Hearing aids and related devices requiring service authorization through KEPRO are the exception. Refer to the EPSDT Hearing and Audiology Manual for detail.

**Processing Service Authorization Requests**

KEPRO or DMAS will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO or DMAS notifies the provider. The member and provider will receive a DMAS system generated letter regarding the status of the request.

If there is insufficient information to make a final determination, the request will be pended back to the provider with a request for additional information. If the information is not received within the requested time frame, the request will automatically be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights in the system generated letter for any adverse determination. Instructions on how to file an appeal are included in the system generated letter.

The Service Authorization Contractor, KEPRO, or DMAS will apply InterQual® criteria (if applicable), DMAS Manuals, Regulations and DMAS modified criteria guidelines to the medical information provided with each service request and a service authorization number will be assigned to the request.

The medical justification provided to the Service Authorization entity must meet the InterQual® Criteria upon review, if applicable. These criteria may be obtained at www.changehealthcare.com/clinical-decision-support-solutions

**SPECIFIC INFORMATION FOR OUT-OF-STATE PROVIDERS**

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request for service authorization as timeliness of the request will be considered in the review process. The request will be

pended for 12 business days to allow the provider to become successfully enrolled.

If confirmation of the provider's enrollment is received within 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and the information is not received within 12 business days, the service authorization request will be rejected as the service authorization cannot be entered without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

**Out-of-State Provider Requests**

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the member's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for members in a particular locality to use medical resources in another state.

The provider needs to determine item 1 through 4 at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

**REVIEW CRITERIA TO BE USED**

EPSDT specialized services are available only for Medicaid members **under age 21.** *EPSDT specialized services are not a covered service by DMAS for members age 21 and older.*

Specialized services through the EPSDT benefit are used to correct or ameliorate physical or mental conditions identified during EPSDT screening services and the member may be referred by the EPSDT screener or Primary Care Provider (PCP) for specific services. These services must be medically necessary with appropriate documentation to support each service authorization request. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. All approvals must meet these agency criteria. All criteria, including InterQual® and/or physician review criteria are used for guidelines and reference purposes only.

EPSDT specialized services are not available under the Virginia *State Plan for Medical Assistance.* Specialized services or items should directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the individuals and environment in which they live.

Services, equipment or supplies already covered by the Virginia *State Plan for Medical Assistance* may not be requested for reimbursement under EPSDT.

*InterQual®:* KEPRO will apply InterQual® criteria to certain services and DMAS criteria where InterQual® does not exist.

**HOW TO DETERMINE IF SERVICES NEED TO BE SERVICE AUTHORIZED**

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and click on the link for Procedure Fee Files & CPT Codes. The information provided through this link indicates if a procedure code needs prior authorization or if a procedure code is not covered by DMAS.

**EXHIBITS**

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## SERVICE AUTHORIZATION EPSDT SERVICES

Exhibit 1

| Service | Children Enrolled in CCC Plus MCOs* | Children Enrolled in Medicaid/ FAMIS Plus Medallion /4.0 MCOs | Children Enrolled in Medicaid/FAMIS Plus Fee-For-Service (FFS) (Includes FAMIS FFS) | Coverage for Children Enrolled in FAMIS MCOs |
|---|---|---|---|---|
| Assistive Technology | Contact child's MCO for service authorization* | Contact child's MCO for service authorization* | Services authorized through KEPRO* | Not covered |
| Hearing Aids, Orthotics, Chiropractic services | Contact child's MCO for service authorization | Contact child's MCO for service authorization | Services authorized through KEPRO | Contact child's MCO for service authorization |
| Private Duty Nursing | Contact child's MCO for service authorization* | Contact child's MCO for service authorization* | Services requested through Atrezzo, authorized by DMAS* | Contact child's MCO for service authorization |
| School Based Private Duty Nursing Included in the child's IEP | Carved out from managed care. Services requested through Atrezzo, authorized by DMAS* | Carved out from managed care. Services requested through Atrezzo, authorized by DMAS* | Services requested through Atrezzo, authorized by DMAS* | Carved out from managed care. Services requested through Atrezzo, authorized by DMAS |

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|---|---|---|---|---|
| School Based Private Duty Nursing **NOT** Included in the child's IEP | Contact child's MCO for service authorization* | Contact child's MCO for service authorization | Services requested through Atrezzo, authorized by DMAS* | Contact child's MCO for service authorization |
| Personal Care | Contact child's MCO for service authorization* | Contact child's MCO for service authorization* | Services requested through Atrezzo, authorized by KEPRO * | Not covered |
| Specialized Medical Formula | Covered by MCO. Contact child's MCO for information. | Carved out from managed care.<br>No service authorization required. | Carved out from managed care.<br>No service authorization required. | Carved out from managed care.<br>No service authorization required. |
| Specialized Inpatient | Contact child's MCO for service authorization* | Contact child's MCO for service authorization | Services authorized through DMAS Medical Services Unit (no specialized inpatient coverage for FAMIS). Fax request to (804)452-5450. | Contact child's MCO for service authorization (coverage for acute only) |
| Behavioral Therapy (including ABA) | Contact child's MCO for service authorization | Contact child's MCO for service authorization Contact Magellan for Service Authorization for fee-for-service members<br>(800)424-4046 | | |
| EPSDT Therapeutic Group Homes | Contact child's MCO for service authorization | Carved out from managed care.<br>Contact Magellan for Service Authorization<br>(800)424-4046 | | Not covered |
| Residential Treatment Centers | Carved out from managed care.<br>Contact Magellan for Service Authorization<br>(800)424-4046 | | | Not Covered |
| Residential Substance Abuse Treatment | Covered through MCO, see current Addiction Recovery and Treatment Services (ARTS) Manual on DMAS website for details:<br>https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual | | | Not Covered |

**with the exception of those children enrolled in the DD Waivers*

Contact information for Medallion 4.0Managed Care Organizations (MCOs) can be found at **www.virginiamanagedcare.com** Contact information for CCC Plus MCOs is located at http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Private duty nursing in the school is available also to MCO members. This is an MCO carved out benefit for children in Medallion if the service is included in the child's IEP. For details concerning this benefit see the EPSDT PDN Manual.

These EPSDT Services are available to members enrolled in the FAMIS MCO benefit: Private Duty Nursing, Hearing Aids, Orthotics, Chiropractic Services, and Behavioral Therapy.

These EPSDT Services are available to members enrolled in the FAMIS Fee-for-Service (FFS) benefit: Assistive Technology, Private Duty Nursing, Hearing Aids, Orthotics,

Chiropractic Services, Behavioral Therapy and Personal Care.

If a child has a medical need for treatment identified during an EPSDT screening that is not covered by the Virginia *State Plan for Medical Assistance* or another EPSDT service, a request for specialized services under EPSDT may be submitted by using the EPSDT Specialized Services Treatment Referral Information Form (DMAS-355) and documentation to describe medical necessity. This form is available on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. If the child is enrolled in managed care, there must be documentation that the request was sent to the MCO for EPSDT consideration but was denied due to not being a covered service.

If the requested service is available through the state plan, the individual sending the request will be referred to the correct DMAS program to obtain the services.

The EPSDT Specialized Services Treatment Referral Information Form must be completed by a physician, physician assistant or nurse practitioner based on health conditions observed during the most recent EPSDT screening. The completed form and any supporting documentation should be faxed to the DMAS at 804-452-5450 or mailed to:

EPSDT Service Authorization Coordinator

Medical Support Unit

600 E. Broad Street

Richmond VA, 23219

**EPSDT TIMELY SUBMISSION CHART**

Exhibit 2: Applies to service authorizations performed by KEPRO and DMAS through the Atrezzo process.

| Service Type | Procedure Codes | Timely Submittal Requirements |
|---|---|---|

| | | |
|---|---|---|
| EPSDT PDN-0090 | S9123, S9124, G0493 and G0494 | Initial requests must be submitted within 10 business days of start of care.<br><br>For continuation of care, the request must be submitted prior to the end date of the current authorized period. |
| EPSDT MCO Carve Out School Services-0098 | S9123, S9124, G0493 and G0494 | Initial requests must be submitted within 10 business days of start of care.<br><br>For continuation of care, the request must be submitted prior to the end date of the current authorized period. |
| EPSDT Personal Care/Attendant Care-0091 | T1019/S5126 | Requests for service authorization must be submitted within 10 business days of start of care.<br><br>For continuation of care, the request must be submitted prior to the end date of the current authorized period. |
| EPSDT Orthotics-0092 | Multiple codes. See DME Manual, Appendix B. | Orthotic requests - No timeframe for service authorization request submission. (Requests may be submitted prior to or after service has been delivered.) |
| EPSDT Chiropratic-0092 | 98940, 98941, 98942, 98943 | Chiropractic service authorization requests must be submitted prior to the service being delivered. |
| EPSDT Hearing Aids and Devices- 0092 | Multiple codes. See EPSDT Hearing and Audiology Manual. | Hearing aid service authorization requests may be submitted by the provider after the hearing aid service has been delivered. |
| EPSDT Assistive Technology 0092 | T5999 | Service Authorization request must be submitted prior to the service being delivered. |

## MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. Individuals aged 19 or 20 who are covered under Medicaid expansion are eligible for EPSDT.